The Illumination Foundation
Pathways to Recovery

Name_____ DOB_____

Intake Date
Identification
Social Security Card
Birth Certificate
DHS Food Stamps
Probation/Parole Notification
Pending Court Dates
Checking/Savings Account
Paycheck Stub
Sponsor Name
Sponsor's Number
Sobriety/Clean Date
Consents/Intake Complete

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Name: _____ Date of Birth: _____

Social Security Number: _____ Male/Female/Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Email: _____

Emergency Contact Information:

Name: _____ Relation: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Are you currently incarcerated? Yes No

If yes, current charges:

_____

_____

_____

Do you have any violent or sex crime convictions? Yes No

Do you have the following?

Birth Certificate: Yes No

Marriage/Divorce Certificate: Yes No

Social Security Card: Yes No

Driver's License/Photo Identification: Yes No

If yes, which is it? DL ID

Are you married? Yes No

Do you have children? Yes No

If yes, how many? _____

If minor children, who has custody?

_____

_____

_____

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Health Insurance: Yes No

If yes, member ID: _____

Primary Care Physician: Yes No

If yes:

Name: _____

Address: _____

Phone Number: _____

Medical Conditions:

_____

_____

_____

_____

_____

Are you currently receiving mental health treatment? Yes No

If yes: Diagnosis:

_____

_____

Therapist/Counselor Name: _____

Contact Information: _____

Are you taking Medications: Yes No

If yes: Are you compliant? Yes No

Name of medication & Dosage:

_____

_____

_____

_____

_____

Do you have a history of substance use disorder? Yes No

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Have you ever been to treatment for substance use disorder? Yes No

If yes, please indicate where, when & if you completed.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list drugs of abuse, how much/how often used & date of your last use:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have a sponsor: Yes No

If yes, name & contact information

Name: _____

Number: _____

SNAP Benefits: Yes No

If no, do you wish to apply: Yes No

Employment: Yes No

If yes:

Where: _____

Hire Date: _____

Supervisor Name: _____

Paycheck Stub: Yes No

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Parole/Probation: Yes No

If yes, officer name & contact information:

Name:_____

Number: _____

County: _____

Pending Court Dates: Yes No

If yes: When:_____

Judge Name:_____

County:_____

Charges_____

_____

_____

_____

_____

Outstanding Fines: Yes No

If yes, how much? And where?

_____

_____

_____

Active warrants: Yes No

If yes, where:

_____

_____

_____

_____

Attorney: Yes No

If yes, name & contact information:

_____

_____

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HS Diploma or GED Yes No

College or Trade School: Yes No

If yes: Degree or
trade:_____

_____

Checking/Savings Acct: Yes No

Vehicle: Yes No

If yes:

Make: _____ Model: _____

Year: _____ Color: _____ License Plate: _____

Insurance: _____

Do you pay child Support or Alimony? Yes No

If yes,

How much: _____

How often: _____

Do you have a safe home environment? Yes No

If yes, where & with whom? _____

_____

_____

Do you have family/friends who are supportive of your recovery? Yes No

Are you interested in Recovery/Transitional Housing? Yes No

Why are you interested in this program? _____

_____

_____

_____

_____

_____

_____

Disposition of Property

I, _____, authorize Illumination Foundation Pathways to Recovery (IFPTR), and any staff or volunteers representing IFPTR to release my property to:

Name: _____

Address: _____

Phone Number: _____

I understand that this party will have (7) SEVEN DAYS from the date of my departure to retrieve my property at which time it will be donated to other people in recovery.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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HOUSE Guidelines

_____ Residents agree to pay $100 per week for program fees. **FEES ARE DUE FRIDAYS BY 6PM**. It must be paid in full and on time. If bi-weekly arrangements need to be made, please see the house director.

_____ Residents agree to give two weeks' notice before their planned departure date. All payments must be paid in full upon departure and the house key must be returned. If a resident is evicted from the house no fees will be refunded.

_____ Residents agree to always abide by curfew or will be subject to administrative action. **MONDAY- THURSDAY--10PM and FRIDAY & SATURDAY 11:00PM**

_____ Residents agree to attend a weekly house meeting. See House Manager for day and time.

_____"One on One" Peer Sessions are voluntary, but resident must agree to work with staff to build recovery plan specific ***for and by*** you. This may include peer groups, clinical counseling, continuing education, service work, trade school, health management and more.

_____ Residents agree to attend the specific number of meetings required from Monday – Sunday. Typically, three meetings per week are required unless otherwise stated in your recovery plan. New residents are encouraged to attend daily, until employment is obtained.

_____ Residents agree to always keep up with meeting sheet. Inability to provide or keep up with the meeting sheet can be subject to administrative action.

_____ Residents agree to be actively seeking full time employment, unless otherwise stated in your recovery plan.

_____ Residents agree to sign in and out of the destination log every time you leave and return to the home.

_____ Residents agree to lock doors at all times and keep up with their assigned door key.

_____ Residents agree to be respectful of the house and its property at all times, as well as staff and all volunteers.

_____ Residents agree not to smoke in the house. Smoking is allowed on the back porch ONLY. Smoking pots will be emptied daily. Not disposing of cigarettes properly could result in administrative action. **DO NOT hang out in the front areas/porches of the homes.**

_____ Residents agree to be fully clothed when going outside of the house for any reason, including smoking.

_____ Residents agree to not burn any candles or have any other fire or flames in the house.

_____ Residents agree to maintain daily chores as assigned and must document with initials on chart when the chore has been completed**. Chores must be done everyday.**

_____ Residents agree to be awake and ready for the day with BEDS MADE by 8:30AM each day.

_____ Residents agree to stay out of other resident's bedroom areas.

_____ Residents agree to keep room cleaned daily; including closets, all clothing items will be in the closet, hanging racks or dresser. Room must always appear neat and organized. Empty beds will be made and will not have any items stored from resident already residing in room, this also includes dressers and other storage areas meant for roommates.

_____ Residents agree to not borrow or lend to other residents in the house. IFPTR is not responsible for items lost or borrowed if rule is not adhered to.

_____ Residents agree there will be no stealing; this can result in immediate eviction.

_____ Residents agree to keep the bathroom clean after each use, i.e. picking up clothes, rinsing out the sink and tub, keeping bottles picked up and orderly, straightening up anything failed to mention.

_____ Resident agrees that there will be no intimate/sexual relationships with another resident(s) of IFPTR-*NOTE: Specialized recovery planning and guidelines will be considered for long term spouses/relationships-this is approved by IFPTR administration.*

_____ Residents agree to turn off any fans or electrical items when leaving the house.

_____ Residents agree to NOT put any Q-tips, paper towels and wipes in the toilets.

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_____ Residents agree to follow laundry procedures designated by house manager.

_____ Residents will keep all food and trash in designated areas and covered.

_____ Residents agree to wash all personal dishes after each use. There should be an empty, clean sink always in kitchen.

_____ Residents agree to not adjust thermostat without house leader's approval.

_____ Residents agree to be considerate of noise level for the entire house when other residents have gone to bed or studying.

_____ Residents agree to always be striving for progression in recovery & life. IFPTR wants you to make the most of this time with us and allow us to help you set and achieve goals that will lead you to the life you desire. We will be available to you for as long as you need providing the guidelines are being followed and progress is being made.

_____ Residents agree to be open-minded concerning 'multiple pathways to recovery'. There is no "one-size-fits-all" approach that works for everyone, and we are here to introduce residents to various recovery methods. Be respectful & supportive concerning other's pathways, and if you can't then say NOTHING AT ALL. We are all trying to learn, grow & heal.

_____ Residents agree to be randomly drug tested by staff. Drugs screens are administered at random each week (1 test) and is included in weekly program fees. Any additional testing is at the resident's cost and is $10 each. This may be for return from pass, or when resident is requesting a test. Denial to submit to a drug screen will be considered a positive test and resident may be evicted. Residents have 2 hours to provide a urine sample after being notified of their test. If resident has positive test, and believes it to be false positive, resident may pay lab fee to have results confirmed. If lab confirms false positive, IFPTR will reimburse resident lab fees.

_____Residents agree there will be absolutely no fighting or aggressive behavior. This will result in immediate eviction.

_____ Residents agree to refrain from spreading gossip about each other in the house.

_____ Residents agree to maintain continuous abstinence from all drugs and alcohol along with non-approved over the counter medications including CBD regardless of the amounts while residing in IFPTR, this will result in immediate eviction and forfeit their program fees.

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_____ Residents agree to active participation in recovery methods of their choosing. We encourage 12 step, Celebrate Recovery and Peer groups, to learn which recovery pathway is for you and meeting sheets must be signed to confirm weekly attendance. IFPTR has partnered with Healthworks to provide free gym memberships to our residents, and we strongly encourage residents to take advantage of this opportunity to build a healthy lifestyle.

_____For AA/NA, residents agree to have a sponsor and be actively working the steps within the first 30 days of admission to IFPTR.

_____Residents agree to give IFPTR staff permission to contact their sponsor/mentor to confirm interaction, if needed. Your chosen recovery must be a pathway of action, self-reflection and self-improvement.

_____ Residents agree not to disrespect other members of the house or staff, i.e., cussing, calling names, being derogatory behind someone's back. Bullying can result in immediate eviction.

_____ Residents agree to keep complete confidentiality in the house. **What happens inside the house stays inside the house**, i.e. sharing at meetings, sharing with family members and friends, Face Timing, sharing on social media. This can cause other people problems in their recovery and could lead someone to leave the house, not go to meetings and then relapse and die. Yes, it's that serous.

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Pathways to Recovery

Release of Liability

This agreement releases Illumination Foundation Pathways to Recovery (IFPTR) from all liability relating to injuries both physical and psychological including death related to overdose or suicide; lost, stolen or damaged property including money; lost rent due to eviction and other issues that may occur during eviction such as not having a place to go and being forced to leave property due to the time restraint given to exit the premises.

I, _____, understand and agree, to follow all guidelines of IFPTR and its staff. I understand failure to do so can lead to my eviction.

I, _____, agree that my person and or property, including my room, my person and my vehicle may be searched at any time by staff. I understand failure to do so can lead to my eviction.

I, _____, understand that in the case of an eviction IFPTR does not provide transportation or placement of person in a safe environment. I understand this means I could be leaving on foot at any time of the day whether AM or PM.

I, _____, agree if I am evicted from IFPTR, I will not receive any refunds of program fees already paid to the facility.

I, _____, understand and consent to the monitoring with video as well as audio surveillance.

I, hereby release the staff, volunteers, Board of Directors and anyone associated with Illumination Foundation Pathways to Recovery from liability, including financial responsibility, in case of any injury or loss/damaged property, referring to both negligent and non-negligent cases caused by IFPTR and residents of IFPTR.

I, understand that by signing this form, I am giving up my right to file a suit against Illumination Foundation Pathways to Recovery for any reason. I will also make every effort to obey safety precautions as listed in writing and as explained to me verbally. I will ask for clarification when needed.

I, _____, fully understand and agree to the above terms.
Printed Name

_____ _____
Signature Date

_____ _____
Witness Date

VIDEO/PHOTO RELEASE FORM

I, _____, hereby grant permission to The Illumination Foundation or anyone associated with its staff, the right to share my image, in video or still, and of the likeness and sound of my voice as recorded on audio or video tape without payment. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area. Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations.
- Courses.
- Online/Internet Videos.
- Media.
- News (Press)

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Street Address/P.O. Box_____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Signature: _____ Date: _____

The Illumination Foundation
Pathways to Recovery

Authorization for Release of Information

I, _____ hereby authorize exchange of information between The Illumination Foundation Recovery Residence and

_____
Name of party releasing information

_____
Agency Name

_____
Address

_____
City, State, Zip Phone

_____ _____ _____
Full Name Date of Birth Social Security Number

Information to be exchanged includes release of information concerning health related conditions, drug or alcohol abuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions.

The information specifically included in this authorization is:

_____ Admission or Discharge Summary
_____ Social/Family History
_____ Physical Examination
_____ School or Job History
_____ Other
_____ Psychological/Psychiatric Assessment
_____ Current/Past Medications
_____ Laboratory Findings
_____ Treatment Plan

_____
Purpose or need of disclosure.

_____
A photocopy of this form is an equivalent of this form.
This information is being disclosed from record the confidentiality of which may be protected by Federal Law.
REDISCLOSURE OF THIS INFORMATION IS STRICTLY PROHIBITED.
I UNDERSTAND THAT THIS CONSENT TO DISCLOSE may be revoked by me at any time by written notice except to the extent that action has been taken thereon. This consent will expire in one year (12 months) after the date below or sooner at my discretion in which case the authorization will expire on _____.

I acknowledge that I have read and fully understand this authorization.

_____ _____
DATE Signature of resident or other legally authorized party

_____ _____
Signature of witness Relationship to resident
Any information about drug and alcohol abuse has been disclosed to you from records protected by Federal Law. Federal regulations prohibit you from making further disclosure without written consent of the person to whom it pertains or is otherwise permitted by such regulation. A general authorization for release of medical or information is insufficient for this purpose.

Updated 9/2023

The Illumination Foundation
Pathways to Recovery

Residents Rights

- House residents have the right to be treated with dignity and respect.
- House residents have the right to privacy at the facility and fulfillment of personal needs.
- House residents have the right to be fully informed of all services available to them.
- House residents have the right to be fully informed of all expectations for their conduct at this facility.
- House residents have the right to know why they are being discharged from the facility.
- House residents have the right to voice their opinions, recommendations, and grievances in relations to policies and services offered without fear of restraint, interference, coercion, discrimination, or revenge.
- House residents have the right to be free from physical, chemical, mental and or sexual abuse.
- House residents have the right to confidentiality of their personal medical records. Information will not be released without prior consent, except in an emergency, required by law or a legal order.
- House residents have the right to retain and use their personal clothing and belongings as space permits. You may have your personal cell phone, tablet/pc and vehicle (as parking permits). IFPTR reserves the right to search/inspect these items if behavior is suspected of putting the health of the house in harm's way.
- House residents have the right to participate in activities of social, religious and community groups of their choice.
- House residents have the right to make and receive telephone calls as well as send and receive mail.
- House residents have the right to have their rights explained to them.

Resident Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Pass Request

Resident's Name: _____

Emergency/Leisure Pass: _____

Job: _____ Current on Rent: _____

Meeting Attendance: _____

Any Write-Ups in within past 7 days? _____

Sponsor's Name/Number/Assignment: _____

Personal Cell #: _____

Address for Pass: _____

_____

_____

Person you will be with, Name & Number: _____

_____

Date (s) of pass Requested: _____

Attached $10 Drug test fee: _____

I agree that if I am I am granted this pass, I will return to house by 4:30 PM on Sunday for drug test. If not on Sunday, then by approved time set by director.

Signature: _____

Approved: _____

Denied: _____

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Drug Screen Log

Name: _____
Date & Time: _____
Observed By: _____
Position: _____

Drug	*Positive*	*Negative*	*Comments*
AMP - Amphetamines 500 ng/ml	_____	_____	_____
BAR - Barbiturates 300 ng/ml	_____	_____	_____
BUP - Buprenorphine 10 ng/ml	_____	_____	_____
BZO - Benzodiazepines 300 ng/ml	_____	_____	_____
COC - Cocaine 150 ng/ml	_____	_____	_____
EDDP - Methadone Metabolite	_____	_____	_____
ETG - Ethyl Glucuronide 500 ng/ml	_____	_____	_____
FEN - Fentanyl 25 ng/ml	_____	_____	_____
K2 - Synthetic Marijuana 25 ng/ml	_____	_____	_____
MDMA - Ecstasy 500 ng/ml	_____	_____	_____
MET - Methamphetamines 500	_____	_____	_____
OPI / MOP - Morphine / Opiates	_____	_____	_____
OXY - Oxycodone 100 ng/ml	_____	_____	_____
PCP - Phencyclidine 25 ng/ml	_____	_____	_____
THC - Cannabinoid (Marijuana)	_____	_____	_____
TRA - Tramadol 100 ng/ml	_____	_____	_____

Signature Date

Staff Signature Date

_____ _____

Name:_____

Meeting Attendance

Date	Group	Chairperson

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Pathways to Recovery

Recovery Capital Assessment Plan and Scale (ReCAPS)

Name: _____ Date: _____

Place a number at the end of each statement reflecting your current situation according to:

1 = Strongly Disagree; **2** = Disagree; **3** = Sometimes Agree; **4** = Agree; **5** = Strongly Agree

1. I have the financial resources to provide for myself and my family. ..... ____
2. I have personal transportation or access to public transportation. ..... ____
3. I live in a home and neighborhood that is safe and secure. ..... ____
4. I live in an environment that is free from alcohol and other drugs. ..... ____
5. I have an intimate partner who supports my recovery process. ..... ____
6. I have family members who support my recovery process. ..... ____
7. I have friends who support my recovery process. ..... ____
8. I have people close to me (partner, family members, or friends) who are also in recovery. ..... ____
9. I have a stable job that I enjoy and that provides for my basic necessities. ..... ____
10. I have an education or work environment that is conducive to my long-term recovery. ..... ____
11. I participate in continuing care that is part of an addiction treatment program, (e.g., outpatient groups, alumni association meetings, etc.) ..... ____
12. I have a professional assistance program that monitors and supports my recovery process..... ____
13. I have a primary care physician who attends to my health condition. ..... ____
14. I am now in reasonably good health. ..... ____
15. I have an active plan to manage any lingering or potential health problems. ..... ____
16. I am on prescribed medication(s) that minimizes my cravings..... ____
17. I have insurance that allows me to receive help for major health problems..... ____
18. I have access to regular, nutritious meals. ..... ____

19. I have clothes that are comfortable, clean and conducive to my recovery activities. ..... ____

20. I have access to recovery support groups in my local community..... ____

21. I have close and regular affiliations with members of local recovery support groups. ..... ____

22. I have a sponsor or mentor related to my recovery. ..... ____

23. I have access to online recovery support groups..... ____

24. I have completed or am complying with all legal requirements related to my past. ..... ____

25. Other people rely on me to support their recoveries. ..... ____

26. My immediate physical environment contains literature, tokens, posters or other symbols of my commitment to recovery. ..... ____

27. I have recovery rituals that are now part of my daily life. ..... ____

28. I had a profound experience that marked the beginning or deepening of my commitment to recovery. ..... ____

29. I have a vision and associated goals and great hopes for my future. ..... ____

30. I have new problem-solving skills and resources. ..... ____

31. I have meaningful, positive participation in my family and community. ..... ____

32. Today I have a clear sense of who I am. ..... ____

33. I know my life's purpose..... ____

34. Service to others is an important part of my life. ..... ____

35. My personal values and sense of right and wrong are clear and strong. ..... ____

Possible Score: 175..... My Total Score: _____
Item numbers on which I scored lowest: _____
Item numbers on which I scored highest: _____

Recovery Capital Assessment Plan and Scale (ReCAPS)

Name: _____ Date: _____

ReCAPS: Date _____: Score _____; Date _____: Score _____; Date _____: Score _____

After completing and reviewing the Recovery Capital Scale, below are my recovery goals for the next month. To move closer to each goal, I will increase my recovery capital by doing the following daily and/or weekly activities.

Goal # 1: _____

	What	When	How Often	With Whom
Activity 1:				
Activity 2:				
Activity 3:				

Goal # 2: _____

	What	When	How Often	With Whom
Activity 1:				
Activity 2:				
Activity 3:				

Goal # 3: _____

	What	When	How Often	With Whom
Activity 1:				
Activity 2:				
Activity 3:				

Adverse Childhood Experiences

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?

   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?

   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?

   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?

   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes No If yes enter 1 _____

10. Did a household member go to prison?

    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

HealthWorks Fitness Center Assistance Program

Objective:

The primary objective of HealthWorks Fitness Center's Assistance Program is to offer preventive wellness services to low income residents who have a medical necessity for a health and fitness program.

Criteria for Enrollment in the Assistance Program:

- Applicants must be under the care of a physician and that physician must clear applicants to participate in a fitness program.
- Applicants must have a medical condition which would benefit from a medically directed health and fitness program.
- Applicant's income levels shall not exceed $16,000 for an individual and $25,000 for a combine (married) household.

To qualify all prospective Assistance Program participants must provide the following:

- Picture Identification
- Physician Referral documentation for the applicant(s)

All participants in HealthWorks Fitness Center's Assistance Program agree to attend the center during the membership year an average of 24 times per quarter (3 months). Any Assistance Program Participant who fails to average at least 24 visits per quarter will be dropped from the program. Once dropped, participants are no longer eligible for the HealthWorks Fitness Center's Assistance Program and must reapply after minimum period of one year. **Participant initials**_____

Assistance Program Participants may place their memberships on inactive status for medical reasons with a note from their primary care physician verifying the medical necessity to temporarily stop exercise. With written consent, participants may place their memberships on hold a minimum of one month and up to 6 months without losing their Assistance Program Membership. Each membership will be reviewed annually to be considered for renewal. **Participant initials**_____

Through the support of the SHARE Foundation, HealthWorks Fitness Center is able to offer Assistance Program Memberships to qualifying residents and their children/legal dependents (ages 12 and under). A membership account will not exceed 8 individuals. A number of these memberships

will be reserved for applicants from Interfaith Clinic. Once this maximum number of is reached, additional prospective members will be placed on a waiting list. When a membership becomes vacant, the next prospective Assistance Program applicant will be evaluated for qualification.

I understand that the center has the right in its' sole discretion to suspend and/or terminate any Membership at any time for any reason, including, by not limited to noncompliance with the Center rules and regulations, behavior deemed by the Center to be harmful to the enjoyment of the Center by other Members, or behavior deemed by the Center to interfere with the job performance of employee(s) of the Center.

Participant initials_____

I understand that if at any time I no longer meet the qualifications for enrollment, I must notify HealthWorks Fitness Center by using one of the contact methods listed below. If any information is found to be untruthful or inaccurate, I will be disqualified from the Assistance Program. Also, I agree to use the facility an average of 24 times per quarter. Failure to average a minimum of 24 visits per quarter will result in my being disqualified from the Assistance Program. Once disqualified, I understand that I can no longer participate in HealthWorks Fitness Center's Assistance Program for a minimum period of one year. After the one-year suspension has expired, I will once again be eligible to reapply for the program.

_____ _____

Signature Date

_____ _____

Witness Date

HealthWorks Fitness Center
304 N Madison Avenue
El Dorado, AR 71730
Phone #: **870-862-5442**
Fax #: **870-862-9922**
HWFCMembership@sharefoundation.com

ASSISTANCE PROGRAM APPLICATION

NAME_____

ADDRESS_____

CITY, STATE ZIP_____

DATE OF BIRTH_____

EMAILADDRESS_____

PHONE NUMBER_____

SPOUSE NAME_____PHONE NUMBER_____

EMPLOYER_____ HOW LONG EMPLOYED_____

EMERGENCY CONTACT_____

PHONE NUMBER_____

ADD-ONS TO MEMBERSHIP
(Children and legal dependents under the age of 12 are eligible for a family membership)

CHILD'S NAME AGE RELATION TO PRIMARY BIRTHDATE

_____

_____

_____

_____

_____

_____

SIGNATURE_____ DATE_____

APPROVED BY_____ DATE _____ CHECKED MEMBER ID_____

Join Date: _____ **PR ____** Training Assessment Date: _____
Assessment Date: _____ **AP ____** Training Assessment Time: _____
Assessment Time: _____ Trainer's Name: _____
Assessment Trainer: _____ Membership Representative: _____

HEALTH STATUS QUESTIONNAIRE

Member Name (Please Print):_____ Member Number: _____

Date of Birth ____/____/____ Age:_____ Gender: ____ Male ____ Female Phone #: _____

Please check if you have a history of the following

_____ Heart attack / Date_____
_____ Heart surgery / CABx_____ Stent #_____
_____ Cardiac catheterization
_____ Coronary angioplasty (PTCA)
_____ Pacemaker/implantable cardiac defibrillator/rhythm disturbance
_____ Heart valve disease
_____ Congestive Heart failure
_____ Heart transplantation
_____ congenital heart disease

Please check if you have any of the following symptoms

_____ Experience chest discomfort with exertion _____ Experience unreasonable breathlessness

Please mark ALL true statements.

____ You are a man older than 45 years
____ You are a woman older than 55 years or you have had a hysterectomy or you are post-menopausal
____ You smoke
____ Your blood pressure is greater than 140/90mmHg
____ You take blood pressure medication / Name _____
____ Your blood cholesterol is greater than 240/mg/dL
____ You have a close blood relative who had a heart attack before age 55(father or brother) or age 65 (mother or sister) / Who and at what age _____
____ You are diabetic or take medicine to control your blood sugar / Insulin _____ Pills _____
____ You have been diagnosed with kidney disease
____ You have pulmonary (lung) problems / O2 requirements _____
____ You have been diagnosed with thyroid or other endocrinological disorder
____ You have respiratory problems, such as asthma, chronic bronchitis, emphysema or COPD
____ You have muscular problems
____ You have arthritis, rheumatism, or gout
____ You have other orthopedic problems
____ You are pregnant
____ You have Multiple Sclerosis
____ You have been diagnosed with osteoporosis
____ You are 20 lbs. or more overweight

Do you have any other medical conditions we need to be aware of?

_____

Please list any previous surgeries and their dates that you have undergone.

Surgery **Dates**

List any other medical conditions that exist and any medications you are currently taking.

Medications **Dosage** **Use**

_____
_____
_____
_____

By Parent/Guardian's/Adult Member's signature below, the Parent/Guardian/Adult Member is verifying that the health information submitted about his/her self on this form is correct and accurate.

_____

Signature **Date**

**A parent or guardian needs to sign for members under 18 years of age.*

INDIVIDUALS AT RISK WHO WISH TO WAIVE THE PHYSICIAN'S CLEARANCE

As an individual with two or more risk factors from the Health Status Questionnaire, I acknowledge that HealthWorks Fitness Center has informed me of the importance of obtaining a physician's clearance. I choose to waive obtaining a physician's clearance at this time and wish to begin an exercise program without my obtaining a physician clearance.

In consideration of being accepted as a member of the HealthWorks Fitness Center, the member agrees to release and hold harmless HealthWorks Fitness Center, SHARE Foundation, its Board of Directors, and their agents, servants, and employees from all claims, liability, demands, rights and causes of action, present or future, whether known, anticipated, or unanticipated, resulting from or arising out of, or incident to Members use of, presence at, or membership in the HealthWorks Fitness Center.

Signature: _____ Date: _____

Print Name: _____

Membership Number: _____

Witness Signature: _____ Date: _____

Print Witness Name: _____

Physician Referral Form

"Building a Healthier Community"

Patient information:

Name: _____

Home Address: _____

City: _____ State: _____

Zip Code: _____ Home Phone: _____

Work Phone: _____ Date of Birth: _____

Email Address: _____

Emergency Contact Name and Phone #: _____

Physician Referral Information

Your patient, listed above, has indicated an interest in participating in one or more of our Conditioning Therapy Programs. In order for him/her to do so, we ask you to please complete the section below. Please list type of Conditioning Therapy Program allowed. Also, indicate any special precautions or limitations applicable to this patient with regard to their level or type of physical activity. Once completed, fax or email to HealthWorks Fitness Center Member Services: Fax: 870-862-9922 Email: hwfcmembership@sharefoundation.com

Diagnosis: _____

Restrictions: _____

Comments: _____

Physician's Phone Number: _____ Clinic Name: _____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

HealthWorks Fitness Center: 304 N Madison, El Dorado, AR 71730
Phone: 870-862-5442 Fax: 870-862-9922 Email: hwfcmembership@sharefoundation.com